Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2015	2014_246196_0016	S-000345-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

Long-Term Care Home/Foyer de soins de longue durée

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LAUREN TENHUNEN (196), BEVERLEY GELLERT (597), DEBBIE WARPULA (577), MARINA MOFFATT (595)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 2, 3, 4, 5, 8, 9, 10, 11, 12, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Clinical Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activation Manager, Recreation staff members, Registered Dietitian (RD), Dietary staff, Housekeeping staff, Maintenance staff, RAI Coordinator, Residents and Family Members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

16 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

On September 9, 2014, Inspector #577 reviewed the care plan specific to pain for Resident #003. The pain focus intervention indicated administration of a particular amount of analgesia and the comfort focus intervention indicated the administration of a different dose of analgesia. The resident had a specialized consultation early in June 2014 and subsequently the physician's orders for analgesia were increased. The current care plan had two different analgesia dosages recorded. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the

resident so that their assessments are integrated and are consistent with and complement each other;

Resident #010 had a wound and the health care records were reviewed for information regarding the treatment of the wound. An assessment note done by the Wound Care RN/Enterostomal Therapist included the recommendation of a therapeutic mattress.

On September 12, 2014, it was confirmed with #S-100 that a therapeutic mattress was not in use on Resident #010's bed. An interview was conducted with #S-101 on September 12, 2014, and it was reported that it was unclear why the recommendation for the use of a therapeutic mattress was not implemented. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On September 4, 2014, Inspector #577 observed Resident #003 lying in bed with 3 bed rails in the up position. The care plan related to bed mobility, indicated that 2 upper bed rails are up at all times for safety and mobility. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On September 9, 2014, Inspector #196 observed the provision of lunch service in a dining room of the home, from 1200 to 1245hrs. The "Diet Census Report" for the unit was reviewed to determine which residents should have received supplements with their lunch meal. No supplements was observed to be provided to any of the residents in the dining room.

An interview was conducted with #S-102 on September 9, 2014, and it was reported that they did not give any supplements to any residents in the dining room. #S-103 was interviewed and reported that they had put protein powder into the main entree of two residents #800 and #812 but did not provide the high calorie beverage as this is to be done by the PSW staff.

After the lunch service, the remainder of the staff in the dining room was questioned by Inspector #196 and it was determined no other supplements were provided to residents except for the two residents identified by one staff member. Residents not receiving supplements as per the plan of care, specifically, as per the "Diet Census Report" were:

#010, #816, #801, #802, #803, #804, $805, #806. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to resident #103, that ensures that the staff and others involved in the different aspects of care of resident #010 collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and ensures that the care set out in the plan of care is provided to resident #003, #010, #816, #801, #802, #803, #804, $805, #806, as specified in their plans, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

A family member reported that there are times in which there is no registered nurse (RN) working in the home due to short staffing. An interview was conducted with #S-104 on September 5, 2014, regarding RN coverage in the home. The schedule for a three month period was provided to the inspector and the shifts in which there was no RN working in the home was identified and included:
- June 2014 - 7 shifts
- July 2014 - 1 shift
- August 2014 - 3 shifts
[s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with.

The policy titled "Two-Step Tuberculin Skin Test Screening for clients" #MED-DIR-T-3 dated January 7, 2010, was provided to the inspector by #S-101 on September 11, 2014 and it noted that "within 14 days of admission a two-step tuberculosis skin test with 5 TU/PPD will be given 1 to 4 weeks apart". Another policy, #IC 1-66 titled "Tuberculosis Management" dated October 2012, was reviewed and it identified that on admission "clients will be assessed for history of tuberculosis and date of last tubercullin skin test (TST)".

The health care records for Residents #807 and #808 were reviewed by the inspector and #S-105 and it was determined that the home's policy and procedure for screening for tuberculosis was not implemented and complied with, for these two particular residents. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, specifically relating to tuberculosis screening, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information to the Director.

As noted in two separate Critical Incident reports submitted to the Director, two incidents of alleged abuse that had occurred in March 2014, were not reported to the Director until June 10, 2014. During an interview with #S-106 it was reported that their first knowledge of these two incidents was in the middle of April 2014, however the incidents were still not reported until June 10, 2014.

Staff members who were aware of the two incidents that had occurred in March 2014, did not immediately bring the information forward to management until the middle of April 2014, as indicated in the CI reports. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information to the Director.

On September 10, 2014, Inspector #595 reviewed the progress notes for Resident #809. It was noted that on a particular day in March 2014, this resident got into an altercation with Resident #810 and Resident #809 sustained an injury. This incident of resident to

resident abuse was not reported to the Director.

Upon further review of Resident #810's progress notes, it was documented that on another day in March 2014, this resident caused injury to Resident #811. This incident of resident to resident abuse was not reported to the Director.

Upon review of the home's policy 'Zero Tolerance of Abuse and Neglect of Residents: Reporting and Notifications About Incidents of Abuse or Neglect' (dated January 2014) it was noted that employees can refer to the MOHLTC Abuse Decision Tree to determine whether to submit a report on an alleged incident of abuse. The Abuse Decision Tree highlights that if a resident suffers from physical injury as a result of the abuse that the licensee is to report to the Director.

Inspector #196 and #595 interviewed #S-106 and it was determined that staff in the home had not brought the first incident forward to management and therefore it was not reported to the Director. #S-106 also confirmed that they were aware of the incident that had occurred later in March 2014, but it also was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

On September 9, 2014, Inspector spoke with Resident #003 about pain and they complained of pain in two different body areas. Later that same day, the Inspector observed the resident lying in bed complaining of a pain in two different body areas and they reported, after the the Inspector inquired if they needed something for pain, that they had received medication already.

On September 9, 2014, Inspector reviewed Resident #003's care plan related to pain and it included several medical diagnoses. The care plan indicated that they had daily moderate pain and interventions included the administration of analgesics.
On September 9, 2014, Inspector reviewed a consultation worksheet from an earlier date, and it identified that this resident continued to have daily pain and the analgesia and dosages were increased.

On September 10, 2014, Inspector #577 spoke with #S-113 and they reported that the clinical pain assessment tool that is used is called the numerical rating scale or the facial rating scale. #S-113 reported that it is expected that staff document the assessment in e-notes, using one of those scales. On September 10, 2014, Inspector reviewed Resident #003's progress notes related to pain from October 2013 to present. The notes did not contain an assessment using a numeric scale or facial scale. [s. 52. (2)]

2. On September 10, 2014, Inspector interviewed #S-115 regarding pain assessments. They reported that pain assessments are done quarterly, and when there has been a change with resident. Inspector spoke with #S-100 about pain assessments and they reported that it is done quarterly and whenever there is a change in residents pain. On September 12, 2014, Inspector interviewed #S-101 who reported that the numeric scale or facial scale is considered the home's clinical pain assessment tool. [s. 52. (2)]

3. On September 10, 2014, Inspector reviewed Resident #006's progress notes related to pain from March 2013 to May 2014, the notes did not contain an assessment using a numeric scale or facial assessment.
On September 11, 2014, Inspector reviewed the annual MDS data for Resident #006, which indicated that the resident has mild, daily pain in two specific areas of their body. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that when resident #003 and #006's pain is not relieved by initial interventions, these residents are assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs (i.e. expiration dates, refrigeration, lighting).

On September 5, 2014, Inspector #597 observed the vaccine refrigerator in the medication room on one of the units of the home. There was an unopened box that contained a 5ml vial of vaccine which was expired June 2014. #S-112 was unsure of who is responsible for checking expiry dates and when they are to be checked.

The Government stock room on one of the home units was observed to have three types of medications expired. #S-101 was made aware of the expired government stock medications and it was reported that the expiry dates are to be checked by the night shift RPN's and an example of the checklist was provided to the inspector. The binder with the checklists on the unit was reviewed and all of the checklist sheets in binder were blank. [s. 129. (1) (a)]

2. The licensee failed ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, (ii) that is secure and locked.

On September 2, 2014, prescription topical medication, was observed at the bedside of Resident #009.

On September 3, 2014, a container of prescription topical cream was located on the bedside table of Resident #010.

On September 6, 2014, two resident care carts were observed in the corridors of one of the home's units. On the top of these care carts were plastic bags containing prescription topical medications with resident names and pharmacy labels. There were two jars of ointment for Resident #814, two tubes of ointment for Resident #815, a jar of ointment for Resident #001 and a tube of ointment for Resident #813.

The location of the resident care carts was brought to the attention of #S-107 who then proceeded to lock the carts in a room off the corridor. [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs (i.e. expiration dates, refrigeration, lighting) and that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program.

On September 2, 2014, Inspector #577 found a blue plastic bedpan sitting on the counter in the shared bathroom in one of the resident rooms. [s. 229. (4)]

2. The licensee has failed to ensure that the following immunization and screening measures are in place: 1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Resident #807 was admitted to the home in the summer of 2014. The health care records for this resident were reviewed on September 12, 2014, with #S-105 and it was determined that this resident had not been screened for tuberculosis within 14 days of admission. In addition, there was no documentation to identify that screening had been done 90 days prior to admission.

Resident #808 was admitted to the home in late fall 2013. The health care records for this resident were reviewed on September 12, 2014, with #S-105, and it was determined that this resident did not have tuberculosis testing until a step one skin test was done in early August 2014. The same staff member reported to the inspector that a step 2 of the skin test was not administered as per the home's policy, as it was an oversight and the home did not have any supply of the serum at that particular time. In addition, there was no documentation to identify that screening had been done 90 days prior to admission. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that all staff participate in the implementation of the infection prevention and control program and ensures that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the

rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of

management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' personal health information is kept confidential.

On September 9, 2014, at approximately 1130hrs, Inspector #196 and #595 observed a registered staff member leave the computer on the medication cart unlocked and unattended with resident information visible on the screen. Inspector #595 observed the same registered staff member leave the medication cart numerous times between 1210 - 1215hrs and did not log off of the computer which had resident information visible.

Inspector #595 spoke with #S-101 and it was reported the home did not have a policy on the use of the medication cart computers and the home's confidentiality policy should have been followed. In addition, it was reported that the expectation is when staff leave the computer/medication cart they are to lock the screen so that resident information is not visible to others. [s. 3. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules are complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On September 2, 2014, Inspector #577 observed two storage rooms on two separate units of the home, unlocked and unsupervised by staff. These unlocked rooms were brought to the attention of staff on each of the respective units and they were then locked. An interview was conducted with #S-106 and it was confirmed that the doors to the rooms that contain electrical panels should always be locked. [s. 9. (1) 2.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) the home, furnishings and equipment are kept clean and sanitary.

Inspector #196 observed on a day in early September 2014, one of the home's common use spa rooms and noted feces on the underside of the seat surface of the tub chair. The following day, the same tub chair was observed to have feces on the underside of the seat surface of the chair, as in the previous day's observation. This was shown to #S-111 and they stated "should've been cleaned". [s. 15. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration program include, (e) a weight monitoring system to measure and record with respect to each resident, (ii) body mass index and height upon admission and annually thereafter.

An interview was conducted with the Registered Dietitian (RD) on September 10, 2014, and it was reported that annual heights are not done on residents of the home and that they are usually only taken on admission. [s. 68. (2) (e) (ii)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness.

On a particular day in early September 2014, during lunch service, Inspector #597 observed staff not following hand hygiene and safe food handling practice. Inspector observed #S-109 pick up a sandwich off of a resident's plate and hand it to the resident. Hand hygiene was not observed prior to handling the sandwich and this same staff member then scratched their head and hair. This same staff member stood watching residents for a few minutes, then went to servery and picked up two plates to show to another resident the food choices. After this, same staff sat down and started to feed another resident. No hand hygiene was observed before, during or after these activities. [s. 72. (3) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) procedures are developed and implemented to ensure that (iv) there is a process to report and locate residents' lost clothing and personal items.

Resident #003 reported to Inspector #577 that they were missing several personal items over a period of time.
On September 11, 2014, Inspector #577 spoke with #S-101 regarding the process to report and locate residents' lost clothing and personal items. This staff reports the process is for staff to do a search on the unit and call the laundry department and there is no form to be completed nor a tracking system for missing property belonging to residents. [s. 89. (1) (a) (iv)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

On September 2, 2014, Inspector #577 entered one of the home units and observed the dirty utility room door to be unlocked. In the bottom cupboard underneath the sink, there were several cleaner chemicals in containers and bottles. Inspector spoke with #S-110 and they reported that the dirty utility room should always be locked and observed the staff proceed to lock it. [s. 91.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the names of staff members involved in the incident were included in the report to the Director.

Upon review of a Critical Incident report it was noted that the accused staff member was not identified throughout the report. When Inspector #595 asked #S-106 to comment, they stated that the missing name was an oversight and therefore not included. [s. 104. (1) 2.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 7. Every release of the device and all repositioning.

On a particular day in September 2014, Resident #011 was observed sitting in a wheelchair with a front release seat belt in place. The health care records were reviewed and included a physician's order for the use of a front release seat belt when in wheelchair for safety and consent from the Substitute Decision Maker (SDM). An interview was conducted with #S-108 and it was confirmed that the resident was unable to release the seat belt on their own and that there was no "restraint monitoring record" for the month of September 2014 despite the resident being in their wheelchair with the seat belt restraint applied. [s. 110. (7) 7.]

Issued on this 25th day of February, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.